TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORCHID MEDICAL

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-17-2048-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MARCH 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reprocess the attached invoice for proper payment. Attached for your review is a letter stating that Acute & Chronic Pain & Spine Center did NOT bill nor provide the implantable instrumentation/supplies billed on the attached invoice. Orchid Medical should be separately reimbursed per agreement."

Amount in Dispute: $2,029.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 7, 2016	Ambulatory Surgical Care for HCPCS Code L8699	$242.00	$242.00
	Ambulatory Surgical Care for HCPCS Code L8681	$1,787.50	$1,787.50
TOTAL		$2,029.50	$2,029.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Texas Labor Code 413.011(b) provides for additions or exceptions to the Medicare policies.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - 11-The recommended allowance for the supply was based on the attached invoice.
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.

Issues

Is the requestor entitled to additional reimbursement for implantables?

Findings

The respondent paid $40,658.00 for HCPCS code L8680, and L8687, but denied payment for L8699 and L8681 based upon reason codes "97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and "243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed." The requestor is seeking reimbursement of $2,029.50 for codes L8699 and L8681.

28 Texas Administrative Code §134.402(d) states, " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

The requestor billed the following codes on the disputed date of service:

- L8680-Implantable neurostimulator electrode, each.
- L8699-Prosthetic implant, not otherwise specified.
- L8687-Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension.
- L8681-Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only.

28 Texas Administrative Code §134.402(b)(5) states "Implantable" means an object or device that is surgically:
(A) implanted,
(B) embedded,
(C) inserted,
(D) or otherwise applied, and
(E) related equipment necessary to operate, program, and recharge the implantable."

A review of the submitted documentation finds that the requestor submitted copies of invoices from St. Jude Medical that lists the description and cost of items. A review of the St. Jude Medical invoice and medical bill indicate the requestor billed code L8681 for the Patient Controller, and L8699 for the Multilead Trial Cable. The Division finds that the documentation supports the Patient Controller and Multilead Trial Cable meet the definition of an implantable per 28 Texas Administrative Code §134.402(b)(5)(E). As a result, reimbursement is recommended.

28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii) states, "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1)

Reimbursement for non-device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

The Division reviewed the invoices and finds the MAR for the implantables per 28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii) is:

Code	Unit Cost	No. of Units	10% not to exceed $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 per admission`480	MAR (Cost + 10%)
L8699	$220.00	1	$22.00	$220.00 + $22.00 =$242.00
L8681	$1,625.00	1	$162.50	$1,625.00 + $162.50 = $1,787.50
TOTAL		2		$2,029.50

The Division finds the total allowable for the implantables is $2,029.50. The respondent paid $0.00. The requestor is due the difference of $2,029.50.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,029.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,029.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	4/5/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.